

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

05756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05755

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN lb 25 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRENE MILES AUD		4. DATE OF DEATH Month APRIL Day 20 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 15, 1891
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) PEARSON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LUTNER F. MILES		14. MOTHER'S MAIDEN NAME JANIE R. HAMMETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 219-56-1931		16. SOCIAL SECURITY NO. B. FRANKLIN AUD LEONARDTOWN, MARYLAND	
17. INFORMANT Address		18. INTERVAL BETWEEN ONSET AND DEATH 1 hr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 4330 Caroline arrest DUE TO (b) Chronic heart failure DUE TO (c) 2 month		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hall bladder surgery			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hall bladder surgery	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.D. Boyd M.D.		22. DATE SIGNED 4/21/67	
EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 22, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE CEMETERY	23d. LOCATION (City or Town) (County) (State) VALLEY LEE, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR APR 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

03325

03326

ST. MARY'S

MARYLAND

ST. MARY'S

LEONARDTOWN

ST. MARY'S

LEXINGTON PARK

ST. MARY'S HOSPITAL

FROM

MILES

AUG

APRIL

NO.

RECEIVED WHITE

X

AUG 1, 1907

ADULT WHITE

HOME

PEARSON

MARYLAND

U.S.A.

LUTHER F. NILES

DAVID F. HAMMERS

210-4-1907

B. FRANKLIN AND

LEONARDTOWN, MARYLAND

Charles L. ...

... ..

WILLIAM D. BOYD M.D.

HOSPITAL

APRIL 22, 1907

ST. GEORGE CEMETERY

MARYLAND

MARYLAND

H. CLARK WATKINS, LEONARDTOWN, MARYLAND

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05756

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SCOTLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SCOTLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First FLORENCE Middle CULLISON Last BISCOE			4. DATE OF DEATH Month APRIL Day 17 Year 19 67		
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 20, 1881		9. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) PENNA.	
13. FATHER'S NAME BENJAMIN HANDY			14. MOTHER'S MAIDEN NAME ELIZABETH TURNER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 28 4647		17. INFORMANT MRS. HELEN WHITE - SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns - (extremes) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH immed
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House fire			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7:00 4-17 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) Scotland		(County) St Mary (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE WM.D. BOYD		M.D. WM.D. BOYD M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) LEONARDTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/20/67		23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEM.	
		23d. LOCATION (City or Town) RIDGE, MARYLAND		(County) (State)	
24. FUNERAL DIRECTOR JOHN M. WELCH		ADDRESS LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR DATE APR 21 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

03125

03125

THE NEW YORK
PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
100 N. 5TH ST. NEW YORK 17, N.Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05758

CERTIFICATE OF DEATH

05757

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ABELL		c. LENGTH OF STAY IN 1b 6 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RURAL ABELL, MD	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET MARY BROOKS		4. DATE OF DEATH Month Day Year APRIL 12, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 25, 1921
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		12. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME MONTANA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Corrosion of Liver DUE TO (b) Alcoholic DUE TO (c) 5811		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 20, 1964 , to April 12, 1967 , that (I) (we) last saw the deceased alive on April 12, 1967 , and that death occurred at 3 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles Greenwell		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 15, 1967	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL, MARYLAND		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR MAY 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

02733

CONFIDENTIAL OF MAIN

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BY VARY

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BY VARY

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RURAL BARKHAYAN

BY VARY

ADLL

BROOKS

BY VARY

MARSHALL

AD

JAN. 22, 1981

BY VARY

WHITE

REAR

ADLL

HOUSE WIFE

LEONARDSON, VARY

CHARLES GREENWELL, W. B.

VARY

CEBAN HILL, VARY

JAN. 15, 1981

REAR

CLARKE, VARY

VARY

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
05758					05758					
1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - HOLLYWOOD 18.1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL					d. STREET ADDRESS RT: 2 BOX 338			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First NOAH Middle WASHINGTON Last CALLIS SR.					4. DATE OF DEATH Month APRIL Day 23 Year 1967					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/1885		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY FARM OWNER		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOHN W. CALLIS					14. MOTHER'S MAIDEN NAME ANN D. WHEATLY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 217 36 5475A		17. INFORMANT MR. NOAH W. CALLIS JR.			Address HOLLYWOOD, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Acidosis 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Pyelonephritis, acute DUE TO (c) Pyelonephritis, chronic								INTERVAL BETWEEN ONSET AND DEATH 1 wk. 3 wk. 5 + y.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.										
22a. SIGNATURE <i>John F. Fenwick</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/24/67			
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M.D.					22d. ADDRESS LEONARDTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 4/25/67		23c. NAME OF CEMETERY OR CREMATORY JOY CHAPEL CEMETERY		23d. LOCATION (City, town or county) (State) HOLLYWOOD, MD.			
24. FUNERAL DIRECTOR <i>John M. Welch</i> JOHN M. WELCH - LEONARDTOWN, MD.					25a. REC'D BY REGISTRAR APR 27 1967 DATE					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

02888

02888

STATE OF TEXAS

Know all men by these presents, that I, *John A. Smith*, of the County of *Dallas*, State of *Texas*, for and in consideration of the sum of *Five Hundred Dollars* to me in hand paid by *John B. Jones*, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said *John B. Jones*, his heirs and assigns forever, all that certain *Tract of Land* situated in the County of *Dallas*, State of *Texas*, containing *Five Acres* or thereabouts, more or less, as the same may appear by the survey and plat of said land, which said plat is on file and of record in the County Clerk's Office of said County, Dallas, Texas, and which said land is more particularly described as follows, to-wit:

Five Acres of Land in the County of Dallas, State of Texas, more particularly described as follows:

Tract of Land in the County of Dallas, State of Texas, containing Five Acres or thereabouts, more or less, as the same may appear by the survey and plat of said land, which said plat is on file and of record in the County Clerk's Office of said County, Dallas, Texas, and which said land is more particularly described as follows:

Tract of Land in the County of Dallas, State of Texas, containing Five Acres or thereabouts, more or less, as the same may appear by the survey and plat of said land, which said plat is on file and of record in the County Clerk's Office of said County, Dallas, Texas, and which said land is more particularly described as follows:

APR 27 1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
05760					CERTIFICATE OF DEATH					05759				
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,			c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RUMXX MECHANICSVILLE 181									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL					d. STREET ADDRESS ROUTE 1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last MILES TAYLOR COLEMAN					4. DATE OF DEATH APRIL 7, 1967 Month Day Year									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 17, 1906		9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE			10b. KIND OF BUSINESS OR INDUSTRY POST OFFICE DEPT.			11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOHN COLEMAN					14. MOTHER'S MAIDEN NAME RUTH TILDEN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES			16. SOCIAL SECURITY NO. 225-05-1505		17. INFORMANT DORIS ANN COLEMAN			Address SAME AS # 2 ABOVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5510 Anoxia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Phrenic nerve entrapment										INTERVAL BETWEEN ONSET AND DEATH 4 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.														
22a. SIGNATURE DAVID MOSSMAN M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4/18/67						
22c. PHYSICIAN'S NAME (Type) DAVID MOSSMAN M.D.					22d. ADDRESS MECHANICSVILLE, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 4/11/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND						
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							

05750

05750

DEPARTMENT OF JUSTICE

ST. MARY'S

MARYLAND

ST. MARY'S

RURAL ROUTE MARYLAND

LEONARDTOWN,

ROUTE 7

ST. MARY'S HOSPITAL

TRAIL

GOLEMAN

TAYLOR

WILSON

DO

DEC. 17, 1908

WHITE

MALE

WASHINGTON, D.C. U.S.A.

POST OFFICE DEPT.

MAIL SERVICE

JOHN TIGER

JOHN TIGER

DATE AS TO ABOVE

25-10-102 JOHN TIGER

YES

MARYLAND

DAVID ROSSMAN, M.D.

MARYLAND

BALTIMORE

BALTIMORE NATIONAL

11/1/07

RURAL

CLARENCE MATTINGLEY LEONARDTOWN, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05761					05760					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)					
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY			
ST. MARY, S		LEONARDTOWN			MARYLAND		ST. MARYS			
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
					RURAL - CHARLOTTE HALL					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
ST. MARYS HOSPITAL								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First		Middle	Last	4. DATE OF DEATH		Month	Day	Year
NETTIE		MAY			DAVIS	APR.		6	19	67
5. SEX	6. COLOR OR RACE	7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE	WHITE	WIDOWED	<input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		AUG. 6, 1883	83 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
HOUSEWIFE			DOMESTIC			MARYLAND		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
WM. W. DYSON					KATE MORAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address
NO					N/A		MRS. MARGARET LUMM			2153 PIERCE ST. NORTH ARLINGTON, VA.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>										<i>instant</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Anterior cross</i>										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary insufficiency, Cerebral thrombosis</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 19 <i>60</i> , to <i>April</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>April</i> , 19 <i>67</i> , and that death occurred at <i>Oct</i> , 19 <i>67</i> , from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
DAVID L. MOSSMAN M.D.					MECHANICSVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL			4/10/67		ALL FAITH CEMETERY		CHARLOTTE HALL, MARYLAND			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOHN M. WELCH - LEONARDTOWN, MD.					APR 11 1967		<i>Charles Judge</i>			

05750

CENTRAL STATE OF DEATH

05750

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
2DM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05762						05761					
1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown 181					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Saint Mary's Hospital						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Fenwick			First Middle Last			4. DATE OF DEATH April 24 1967			Month Day Year		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-67		9. AGE (In years last birthday) yrs. 18		IF UNDER 1 YEAR Months 05 Days 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. Mary's County, Maryland			12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME Alvin Joseph Marshall						14. MOTHER'S MAIDEN NAME Mary Ethel Fenwick					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother			Address Leonardtown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (6 months) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) — c) —						INTERVAL BETWEEN ONSET AND DEATH 36 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE Ernest D. Rehm						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 26 April 67		
22c. PHYSICIAN'S NAME (Type) Ernest Rehm M.D.						22d. ADDRESS James Building, Lexington Park, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/29/67		23c. NAME OF CEMETERY OR CREMATORY St Aloysius			23d. LOCATION (City, town or county) (State) Leonardtown, Md			
24. FUNERAL DIRECTOR McClure Wattingly						ADDRESS Leonardtown, Md			25a. RECEIVED BY REGISTRAR MAY 2 1967		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05763					05762				
1. PLACE OF DEATH a. COUNTY ST. MARYS b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 15/ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARYS HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK d. STREET ADDRESS 5 37 ESSEX DR. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First PATRICK Middle LAMB Last GORDON M.D.			4. DATE OF DEATH Month APRIL Day 11 Year 19 67						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/1873		9. AGE (in years last birthday) 93 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - MEDICAL DOC.				10b. KIND OF BUSINESS OR INDUSTRY MEDICINE		11. BIRTHPLACE (County & State, or foreign country) CAMDEN, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS GEORGE GORDON					14. MOTHER'S MAIDEN NAME MARY ELIZABETH LAMB				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. WW I 233 24 8216 A		17. INFORMANT Address MISS ELLEN W. GORDON - SAME AS # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonitis								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 17 Feb, 1967 to 4-11, 1967 , that (I) (we) last saw the deceased alive on 4-11-67 , and that death occurred at 6:47 AM from the causes and on the date stated above.									
22a. SIGNATURE J.C. Roa M.D.					22b. DATE SIGNED 4/11/67		22c. PHYSICIAN'S NAME (Type) J.C. ROA M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT					23b. DATE THEREOF 4/13/67		23c. NAME OF CEMETERY OR CREMATORY CHARLESTON, WEST VIRGINIA		23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR JOHN M. WELCH					25a. REC'D BY REGISTRAR APR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		
26. ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
05764		CERTIFICATE OF DEATH		05763	
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 15 21 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MORGANZA, RURAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM MATHEW HOLT		4. DATE OF DEATH APRIL 16, 1967		Month Day Year	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1896	9. AGE (In years lost birthday) yrs. 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM HOLT		14. MOTHER'S MAIDEN NAME ADA DORSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ETHEL M. HOLT Address MORGANZA, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Tumors and hemorrhages		INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/19/67	
22c. PHYSICIAN'S NAME (Type) DAVID MOSSMAN M.D.		22d. ADDRESS GREAT MILLS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 20, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPHS	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR APR 21 1967	
				25b. REGISTRAR'S SIGNATURE 	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05764

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEXINGTON PARK		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEXINGTON PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 3 ADAMS PLACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last THELMA THERESA HURT			4. DATE OF DEATH Month Day Year APRIL 13, 19 67		
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 12, 1967		9. AGE (In years lost birthday) yrs. 8 days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARKLAND	
13. FATHER'S NAME FRANCIS STEWART			14. MOTHER'S MAIDEN NAME BARBARA HURT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MOTHER Address SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William D. Boyd		M.D. WILLIAM D. BOYD M.D.		22. DATE SIGNED 4/15/67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 14, 1967		23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEMETERY	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		23d. LOCATION (City or town) (County) (State) LEONARDTOWN, ST. MARY'S, MD	
25a. REC'D BY REGISTRAR APR 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

7-215317

05734

05734

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ST. MARY'S

MARYLAND

ST. MARY'S

RURAL LEXINGTON PARK

LIFE

RURAL LEXINGTON PARK

3 ADAMS PLACE

APRIL 12,

FORT

THEATER

THEATER

MARCH 12, 1907

FEMALE

U.S.A.

MARYLAND

BARBARA - OUT

FRANCIS STEWART

MOTHER - DAY AS A 2 ADAMS

ST. MARY'S, ST. MARY'S

APRIL 14, 1907 ST. ALDOUS CEMETERY

BURIAL

W. CLARK MATTHEW LEE, LEONARDTOWN, MARYLAND

Handwritten signature

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07206

FOR STATE
HEALTH DEPT.

07228

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Gardiner's Mill c. LENGTH OF STAY IN 1b Found: In stream or water on Mechanicsville-Chaptico Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ST. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell d. STREET ADDRESS 18-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH KENNETH JONES		4. DATE Found: Month Day Year 4 25 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-02
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Mm. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY OYSTER & FISH	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES D. JONES		14. MOTHER'S MAIDEN NAME ANN E. HOPPS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 16 4656	
17. INFORMANT MARY L. MACK - COLTON POINT - MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian - Presumably struck by auto then thrown in stream	
20c. TIME OF INJURY Month, Day, Year Hour o.m. Unknown p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Unknown	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		22. DATE SIGNED 5-5-67	
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/8/67	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY	23d. LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND
24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR MAY 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

2357

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INDEX

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05766

CERTIFICATE OF DEATH

05765

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 18/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ELIZABETH ABELL MATTINGLY		4. DATE OF DEATH Month APRIL Day 16 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ENOCH BOOTH ABELL		14. MOTHER'S MAIDEN NAME KATHERINE CAMALIER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS ELOISE STOKEL LEONARDTOWN, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John P. Fenwick		22b. DATE SIGNED 4-17-67	
22c. PHYSICIAN'S NAME (Type) JOHN P. FENWICK M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEMETERY		23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DA APR 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

05753

OFFICE OF THE

1905

ST. MARY'S

MARYLAND

ST. MARY'S

LEONARDTOWN

LEONARDTOWN

ST. MARY'S HOSPITAL

MARY ELIZABETH ADAMS BATTISLEY

SEPT. 1, 1905

WHITE

MARYLAND

HOME

HOUSE WIFE

KATHERINE DANIELS

EMERSON ADAMS

MRS. FLORENCE STOKES LEONARDTOWN, MARYLAND

Handwritten signature

LEONARDTOWN, MARYLAND

JOHN F. FENWICK, M.D.

APRIL 18, 1905 ST. ALVIN'S CHURCH, LEONARDTOWN, MARYLAND

LEONARDTOWN, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05767

CERTIFICATE OF DEATH

05766

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN lb 20 HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS LAWRENCE AVENUE	
3. NAME OF DECEASED (Type or print) WILLIAM DOMNICK MATTINGLY		4. DATE OF DEATH Month APRIL Day 11 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 4, 1886
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY FARM EQUIPMENT	
11. BIRTHPLACE (County & State, or foreign country) LEONARDTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CLEMENT MATTINGLY		14. MOTHER'S MAIDEN NAME MARY MAGDALENE HAYDEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT AMANDA MATTINGLEY		Address LEONARDTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Exsanguination Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured Aortic Aneurysm DUE TO Arteriosclerosis (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 min 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 to 4/11 , 19 67 that (I) (we) lost the deceased alive on 4/11 and that death occurred at 4:55 M. from causes on and on the date stated above.			
22a. SIGNATURE James P. Jarboe		22b. DATE SIGNED 4/11/67	
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 14, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEMETERY	23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, ST. MARY'S, MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR APR 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

5756

STATE OF OHIO

05756

ST. MARY'S

VARYLAND

ST. MARY'S

LEONARDTOWN

50 MAR

LEONARDTOWN

ST. MARY'S HOSPITAL

LARRYING AVENUE

WILLIAM

DOMINICK

MATTIELEY

APRIL

JUNE 4, 1906

WHITE

SALLY MAN

ARMY ENLISTMENT

LEONARDTOWN, VARYLAND

WILLIAM CLEMENT MATTIELEY

MARY MADDIE DE VAYDEN

AMANDA MATTIELEY

LEONARDTOWN, VARYLAND

JAMES R. JARROT V. O. LEONARDTOWN, VARYLAND

APRIL 14, 1907 ST. JOSEPH CEMETERY LEONARDTOWN, ST. MARY'S, CO.

W. JARROT MATTIELEY LEONARDTOWN, VARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05768

CERTIFICATE OF DEATH

05767

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MACK MUNGO				4. DATE OF DEATH Month APRIL Day 27 Year 19 67			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 5, 1878	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) LANCASTER, SOUTH CAROLINA U.S.A.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME LOUIS MUNGO			
14. MOTHER'S MAIDEN NAME MARGARET BLADNIE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. 251-86-6974				17. INFORMANT MATTIE GATES LEXINGTON PARK, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4500 DUE TO (b) Amputated Left Lower Extremity DUE TO (c) Arterio-sclerosis				INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 days 30 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April, 1967 to 27 April, 1967 , that (I) (we) last saw the deceased alive on 27 April 19 67 , and that death occurred at 4:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE Ernest D. Rehm				22b. DATE SIGNED 30 April 67		22c. PHYSICIAN'S NAME (Type) ERNEST REHM	
22d. ADDRESS LEXINGTON PARK, MARYLAND				22e. REC'D BY REGISTRAR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/1/67		23c. NAME OF CEMETERY OR CREMATORY Cross Road.	
23d. LOCATION (City or Town) (County) (State) Lancaster S.C.				23e. REGISTRAR'S SIGNATURE J. Charles Judge			

A. CLARK BATTINLEY, LEONARDTOWN, MARYLAND

MAY 2, 1917

LEONARDTOWN

LEONARDTOWN PARK, MARYLAND

LEONARDTOWN PARK, MARYLAND

LEONARDTOWN PARK, MARYLAND

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LEONARDTOWN PARK, MARYLAND

LEONARDTOWN

LEONARDTOWN PARK, MARYLAND

LEONARDTOWN

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MAY 2, 1917

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05769

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		d. STREET ADDRESS RURAL GREAT MILLS,	
3. NAME OF DECEASED (Type or print) VIOLET BEAN NORRIS		4. DATE OF DEATH Month APRIL Day 15 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1902
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS W. BEAN		14. MOTHER'S MAIDEN NAME ELIZABETH EVANS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ELMER LEE NORRIS		Address LEONARDTOWN, MD STAR ROUTE Box 39	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO (b) Massive myocardial infarction DUE TO (c) Essential hypertension		INTERVAL BETWEEN ONSET AND DEATH min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. (CONDITION GIVEN IN PART I(a))		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/15/67 , 19 67 , that (I) (we) last saw the deceased alive on 4/15/67 , 19 67 , and that death occurred at 9:45 PM from causes and on the date stated above		22a. SIGNATURE JAMES P. JARBOE	
22b. DATE SIGNED 4/18/67		22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.	
22d. ADDRESS GREAT MILLS, MARYLAND		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY HOLY FACE CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. RECORD BY REGISTERED 1967	
25a. RECORD BY REGISTERED 1967		25b. RECORD BY REGISTERED 1967	

03703

CENTRAL OF MARYLAND

03703

ST. MARY'S

MARYLAND

ST. MARY'S

RURAL GREAT HILLS

2 DAYS

LEONARDTOWN

ST. MARY'S HOSPITAL

03

12

APRIL

MORRIS

DEAN

VIOLET

AUGUST 11, 1902

EMMA WHITE

12

MARYLAND

HOMER

HOUSE WIFE

ELIZABETH EVANS

THOMAS F. DEAN

LEONARDTOWN, MD

CLARENCE MORRIS STAR ROUTE BOX 33

GREAT HILLS, MARYLAND

JAMES P. JARVIS M. D.

MARYLAND

GREAT HILLS

JOHN PAGE DENTISTRY

APRIL 15, 1902

BURIAL

W. CLARK BATTISLEY LEONARDTOWN, MARYLAND

FOR STATE HEALTH DEPT

05770

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05769

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARYS b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills, c. LENGTH OF STAY IN lb Lexington Park d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) near Clydes Tavern		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park d. STREET ADDRESS 53 E. Rennel Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen Patricia PILKERTON		4. DATE OF DEATH (Pronounced) Month Day Year April 16, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1945
9. AGE (In years lost birthday) 21 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN S. PILKERTON		14. MOTHER'S MAIDEN NAME ELIZABETH DEAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT JOHN S. PILKERTON		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple blunt and penetrating injuries of head, neck and thorax 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed and struck numerous times	
20c. TIME OF INJURY Month, Day, Year About 2:30 am 4-16 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) woods
20f. (City or town) (County) (State) St. Marys			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED April 17, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 20, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEMETERY
23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, ST. MARY'S, MD.			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE APR 21 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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U.S.A.

MARYLAND

ELIZABETH DEAN

JOHN S. PICKERTON

JOHN S. PICKERTON

BURIAL APRIL 20, 1945 ST. JOHN'S CEMETERY

APR 21 1945

W. CLARK ATTORNEY LEONARDTOWN, MARYLAND

FOR STATE
HEALTH DEPT.

05771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05770

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Balance before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEMENTS		c. LENGTH OF STAY IN lb RURAL - BRANDYWINE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RT. 1 BOX 34	
3. NAME OF DECEASED (Type or print) First Middle Last JOHNNIE PRESTON RIGSBEE		4. DATE OF DEATH Month Day Year APRIL 2 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/1929
9. AGE (In years lost birthday) yrs. 38		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY AUTO & TRAILER	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RUFUS RIGSBEE		14. MOTHER'S MAIDEN NAME ANNIE TAPP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. CAROLYN M. RIGSBEE - SAME AS # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inguiries (head & chest) Multiple Extremities DUE TO (b) Interval between onset and death DUE TO (c) inward		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto accident - Thrown from car	
20c. TIME OF INJURY Month, Day, Year Hour 6:55 p.m. 4-2 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 234		20f. (City or town) (County) (State) Clement S + May Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WM. D. BOYD M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) LEONARDTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE THEREOF 4/4/67	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) DURHAM, NORTH CAROLINA	
24. FUNERAL DIRECTOR John M. Welch		ADDRESS LEONARDTOWN, MD.	
25a. REC'D BY REGISTRAR APR 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05772		Item #1d Film# 550 7/17/67		CERTIFICATE OF DEATH		05771			
1. PLACE OF DEATH a. COUNTY ST. MARY, S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lawrence Avenue (Home)					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY, S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN d. STREET ADDRESS 18-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First BARNARD Middle INGHAM Last SMITH			4. DATE OF DEATH Month APRIL Day 27 Year 1967						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/20/1900		9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBING & ELEC.			10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED			11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES W. SMITH					14. MOTHER'S MAIDEN NAME EDITH INGHAM				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 215 32 0299		17. INFORMANT MRS. DOROTHY W. SMITH Address LEONARDTOWN, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 260X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Diabetes mellitus								INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE 					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/29/67		
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M.D.					22d. ADDRESS LEONARDTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 4/30/67		23c. NAME OF CEMETERY OR CREMATORY CHRIST EPISCOPAL CEM.		23d. LOCATION (City, town or county) (State) PORT REPUBLIC MD.		
24. FUNERAL DIRECTOR  JOHN M. WELCH					ADDRESS LEONARDTOWN MD.		25a. REC'D BY REGISTRAR MAY 2 1967 25b. REGISTRAR'S SIGNATURE 		

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05772

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COPIES DESTROYED 1964

MAY 1964

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05773

CERTIFICATE OF DEATH

05773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HOLLYWOOD c. LENGTH OF STAY IN 1b 17 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HOLLYWOOD d. STREET ADDRESS 181 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS LUCILLE SMITH		4. DATE OF DEATH Month Day Year APRIL 13, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1905
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CHARLOTTE, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR D. VANDERBURGH		14. MOTHER'S MAIDEN NAME MINERVA L. HAYES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HAROLD J. SMITH		Address HOLLYWOOD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct DUE TO (b) Coronary thrombosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinomatosis from carcinoma of the ovaries.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE A. Samadi		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. SAMADI M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 16, 1967	23c. NAME OF CEMETERY OR CREMATORY MT. ZION	23d. LOCATION (City or Town) (County) (State) LAUREL GROVE, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. REC'D BY REGISTRAR DATE APR 18 1967	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE [Signature]	

05773

DEPARTMENT OF HEALTH

05773

87, MAY 18

MARYLAND

ST. MARY'S

RURAL HOLLYWOOD

17 YEARS

RURAL HOLLYWOOD

67

17

APRIL

SMITH

LUDILE

FRANCIS

X

62

APRIL 1, 1902

WHITE

FEMALE

CHARLOTTE, NORTH CAROLINA (U.S.A.)

HOUSE WIFE

MARYLAND

ARTHUR D. VAN DERBURG

HAROLD J. SMITH HOLLYWOOD, MARYLAND

LEONARDTOWN, MARYLAND

A. SAMADY M. D.

MARYLAND

LAUREL GROVE,

APRIL 10, 1902

LUDILE

H. CLARK HATTLEY, LEONARDTOWN, MARYLAND

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

05774

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05772

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PARK HALL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GREAT MILLS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RT. 1 BOX 402	
3. NAME OF DECEASED (Type or print) First Middle Last DENNIS LEE STANLEY		4. DATE OF DEATH Month Day Year APRIL 13 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2, 1963
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) BRISTOL, TENN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELLIS LEE STANLEY		14. MOTHER'S MAIDEN NAME MARY ANN THOMAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT MRS. MARY ANN STANLEY - SAME AS # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) CRUSHING HEAD INJURIES EXTREME DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH TWO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) VEHICLE LEFT HWY. STRIKING BRIDGE ABUTMENT	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:18 P.M. 4/13/67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STATE RT. # 5		20f. (City or town) (County) (State) PARK HALL ST. MARYS MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Wm.D. Boyd</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WM.D. BOYD M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) LEONARDTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/17/67	
23c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		23d. LOCATION (City or Town) (County) (State) WALDORF, MARYLAND	
25a. REC'D BY REGISTRAR DATE APR 18 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FUNERAL DIRECTOR
John M. Welch
JOHN M. WELCH - LEONARDTOWN, MD.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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05775

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05774

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland/ Va. b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAS, Patuxent River, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nas, Patuxent River, Maryland	
c. LENGTH OF STAY IN lb 3 weeks		d. STREET ADDRESS Bks. 411/ 5650 Fenwick Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Edward VORNBAUM		4. DATE OF DEATH Month Day Year April 7 1967	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 36 yrs.
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins. 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William VORNBAUM (Deceased)		14. MOTHER'S MAIDEN NAME Helen (Foljinski) VORNBAUM (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 3JUN63-7APR67 144-24-0513	
17. INFORMANT Official Naval Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoxia (cause undetermined) DUE TO 795.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE C. F. MACCARREY, LT MC USNR		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. B. BOID, M.D., County Coroner		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 7 APR 67		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Cemetery		23d. LOCATION (City or Town) (County) (State) Fairfax Co. Va.	
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home, Alex. Va.		25a. REC'D BY REGISTRAR APR 17 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

05774

05775

05776

CERTIFICATE OF DEATH

05775

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS MEDLEY'S NECK	
3. NAME OF DECEASED (Type or print) JAMES H. WALLACE		4. DATE OF DEATH APRIL 7, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1886
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Hollywood Md.
13. FATHER'S NAME XXXXX TAHLWOOD WALLACE		14. MOTHER'S MAIDEN NAME SARAH GATTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MACE FORD		Address LEONARDTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-4 , 19 67 , to 4-7 , 19 67 , that (I) (we) lost saw the deceased alive on 4-7 , 19 67 , and that death occurred at 4-7 M, from causes and on the date stated above.			
22a. SIGNATURE W.D. Boyd		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 10, 1967	23c. NAME OF CEMETERY OR CREMATORY OUR LADY'S CHAPEL	23d. LOCATION (City or Town) (County) (State) MEDLEY'S NECK, ST. MARY'S, MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR APR 11 1967	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAINTENANCE OF RECORDS IN MARYLAND
OFFICE OF THE ATTORNEY GENERAL

05775

OFFICE OF DEATH

05775

ST. MARY'S MARYLAND ST. MARY'S

LEONARDTOWN 3 DAYS LURAL LEONARDTOWN

WOLLEY'S BECK

JAMES H. WALLACE ST. MARY'S

WHITE

SAKRA TAYLOR WALLACE

MACE FORD LEONARDTOWN, MARYLAND

CNA

ST. MARY'S MARYLAND

WILLIAM D. BOYD, D. LEONARDTOWN, MARYLAND

APRIL 10, 1907 OUR LADY'S CHURCH WOLLEY'S BECK, ST. MARY'S, MD.

WILLIAM D. BOYD, D. LEONARDTOWN, MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05777

05776

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - DAMERON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - DAMERON 181			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE ANN WOOD				4. DATE OF DEATH Month Day Year APRIL 21 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/1940	9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY E. WOOD				14. MOTHER'S MAIDEN NAME HATTIE C. Mc KAY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. N/A		17. INFORMANT MRS. HATTIE C. McKAY		Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Sepsis (c) Pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Retardation							INTERVAL BETWEEN ONSET AND DEATH hrs days hrs
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 4/21/67 , 19 66 , to 4/21 , 19 67 , that (I) (the hospital) saw the deceased alive on 4/21/67 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE J. P. Jarboe				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/21/67	
22c. PHYSICIAN'S NAME (Type) J. P. JARBOE M.D.				22d. ADDRESS GREAT MILLS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/24/67		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEM.		23d. LOCATION (City, town or county) (State) RIDGE, MARYLAND	
24. FUNERAL DIRECTOR JOHN M. WELCH				25a. REC'D BY REGISTRAR APR 25 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jago	

03770

RECEIVED OF BATH

03770

1921